

7138

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. **350**

FILED FEB 21 1950

BIRTH NO. _____		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 6076	
1. PLACE OF DEATH a. COUNTY ST. LOUIS			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE ILLINOIS b. COUNTY MADISON		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN MANCHESTER			c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN GRANITE CITY		
d. FULL NAME OF HOSPITAL OR INSTITUTION MANCHESTER NURSING HOME			d. STREET ADDRESS (If rural, give location) 2020 14th STREET		
3. NAME OF DECEASED (Type or Print) a. (First) JOSEPH b. (Middle) — c. (Last) FUNTA			4. DATE OF DEATH (Month) (Day) (Year) FEB 8 1950		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 3	
8. DATE OF BIRTH SEP 18 1878		9. AGE (In years last birthday) 72		10. UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) BUDAPEST HUNGARY		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME ?		13b. MOTHER'S MAIDEN NAME ?		14. NAME OF HUSBAND OR WIFE ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 333-03-SL2LA		17. INFORMANT'S SIGNATURE OR NAME Frank Lakatos ADDRESS 1829 Cedar St	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ch. Myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) Senility II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT <input checked="" type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb 6, 1950 , to Feb 8, 1950 , that I last saw the deceased alive on Feb 8, 1950 , and that death occurred at 6:30 AM , from the causes and on the date stated above.					
23a. SIGNATURE Ed Henry		23b. ADDRESS Creve Coeur, Mo		23c. DATE SIGNED 2-8-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Bur		24b. DATE 2-10-50		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
24d. LOCATION (City, town, or county) (State) Edwardsville Ill		25. FUNERAL DIRECTOR'S SIGNATURE Leonard R. Davis ADDRESS 2060 Cleveland			

(Licensed Embalmer's Statement on Reverse Side)

Granite City, Ill

WRITE PLAINLY USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Signed
Student Embalmer

Signed

Leonard R. Davis

Licensed Embalmer No. 8375

P. O. Address 2860 Cleveland
Granite City, Pa.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.